MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF HOME CARE AND REHABILITATIVE STANDARDS

STATE HOSPICE - CERTIFICATION

NAME OF FACILITY	STREET ADDRESS	CITY	STATE	ZIP CODE

NAME OF SURVEYOR	DATE SURVEY COMPLETED

GEOGRAPHIC AREA SERVED

TAG #	YES	NO	
			19 CSR 30-35.010 Hospice Program Operations
			(1) General Provisions
			(A) Definitions Relating to Hospice Care Agencies
			1. Hospice administrator—the employee designated by the governing body as responsible for the overall functioning of the hospice.
			2. Attending physician—a person who— A. Is licensed as a doctor of medicine or osteopathy in this state or a bordering state; and B. Is identified by the patient, at the time s/he elects to receive hospice care, as having the most significant role in the determination and delivery of the patient's medical care.
			3. Contracted provider—individuals or entities who furnish services to hospice patients under contractual arrangements between the hospice and the contracted provider.
			4. Coordinating provider—any individual or agency which independently provides services to the patient in their place of residence.
			5. Dietary counselor—an individual that is currently eligible to be licensed as a dietitian in Missouri or recognized as a nutritionist.
			6. Direct employee—an individual paid directly by the hospice.
			7. Employee—an employee of the hospice or an individual under contract who is appropriately trained and assigned to the hospice program. Employee also refers to a person volunteering for the hospice program.
			8. Family—broadly defined to include not only persons bound by biology or legalities but also those who function for the patient in a familial way.
			9. Homemaker—a home health aide, volunteer or other individual who assists the patient/family with light housekeeping chores.
			10. Home health aide—a person who meets the training, attitude, and skill requirements specified in the Medicare home health program (42 CFR 484.36).

EXPLANATORY STATEMENTS

			11. Hospice—a public agency or private organization or subdivision of either that: A. Is primarily engaged in providing care to dying persons and their families; And B. Meets the standards specified in 19 CSR 30-35.010 and in 19 CSR 30-35.030. If it is a hospice that provides inpatient care
			12. Hospice patient—a person with a terminal illness or condition for whom the focus of care is on comfort and palliation rather than cure.
			13. Licensed practical nurse—a person licensed under Chapter 335, RSMo to engage in the practice of practical nursing.
			14. Meal preparation—meals planned, offered or served to all patients from prepared menus.
			15. Medical director—a person licensed in this state or a bordering state as a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospice's patient care program.
			16. Nutritionist—a person who has graduated from an accredited four year college with a bachelor's degree including or supplemented by at least 15 semester hours in food and nutrition including at least one course in diet therapy.
			17. Occupational therapist—a person who is registered under Chapter 334, RSMo as an occupational therapist and licensed to practice in Missouri.
			18. Occupational therapy assistant—a person who has graduated from an occupational therapy assistant program accredited by the Accreditation Council for Occupational Therapy Education and licensed to practice in Missouri.
			19. Registered nurse—a person licensed under Chapter 335, RSMo to engage in the practice of professional nursing.
			20. Registered nurse coordinator—a registered nurse, who is a direct employee, designated by the hospice to direct the overall provisions of clinical services.
			21. Pharmacist—a person licensed as a pharmacist under Chapter 338, RSMo.
			22. Physician—a physician as defined in subparagraph (1)(A)2.A. of this rule.
			23. Physical therapist—a person who is licensed as a physical therapist under Chapter 334, RSMo.
			24. Physical therapy assistant—a person who has graduated from at least a two-year college level program accredited by the American Physical Therapy Association and licensed to practice in Missouri.
			25. Legal representative—a person who because of the patient's mental or physical incapacity is legally authorized in accordance with state law to act on behalf of the dying person.
			26. Satellite/branch office—a location or site from which a hospice provides services within a portion of the total geographic area served by the parent hospice and the area served by the satellite/branch office is contiguous to or part of the area served by the parent hospice.
			27. Skilled nursing—those services which are required by law to be provided by a registered nurse or a licensed practical nurse.
			28. Snack—a single meal or item prepared on demand which does not include

			food items that produce grease-laden vapors.	
			29. Social worker—a person who has at least a bachelor's degree in social work from a school of social work accredited by the Council on Social Work Education.	
			30. Speech language pathologist—a person who is licensed under Chapter 345, RSMo as a speech therapist.	
			31. Spiritual counselor—a person who is ordained, commissioned or credentialed according to the practices of an organized religious group and has completed, or will complete by August 1, 2003, one unit of Clinical Pastoral Education (CPE); or has a minimum of a bachelor's degree with emphasis in counseling or related subjects and has, within ninety days of hire, completed specific training to include: common spiritual issues in death and dying; belief systems of comparative religions related to death and dying; spiritual assessment skills; individualizing care to patient beliefs; and varied spiritual practices/rituals.	
			32. Standing order—An order by an authorized prescriber that can be implemented by other health care professionals when predetermined criteria are met as per 19 CSR 30-35.010(2)(E)3.–(2)(E)4.A., B. and C.	
ML100			**(B) Eligibility Requirements.** A hospice shall have written admission criteria including the hospice's policies regarding palliative care (that include treatment modalities such as chemotherapy or radiation).	
ML101			**(C) Consent for Hospice Care.** 1. A patient who wishes to receive hospice care, shall sign a consent form for hospice services.	The patient's legal representative may also sign a consent form for the patient.
ML102			2. The consent form shall include the following: A. Identification of the particular hospice that will provide care to the patient; B. The patient's or representative's acknowledgment that s/he has been advised and has an understanding of the palliative nature of hospice care as it relates to the patient's terminal illness; C. The specific type of care and services that may be provided as hospice care during the course of the illness.	
ML103			**(D) Discontinuance of Hospice Care.** 1. A patient or legal representative may discontinue the patient's hospice care at any time.	
ML104			2. If a patient transfers to another provider, including another hospice provider, the hospice transferring care shall provide to the receiving provider pertinent written information which shall include at a minimum: A. Current medication profile; B. Advance directive (if applicable); and C. Problems that require intervention or follow-up.	Item C: The receiving hospice should be made aware of those problems that reflect the unique and immediate needs of the patient; it is not necessary to send the entire plan of care.
ML105			3. The hospice shall have written policies for hospice patient discharge which identify specific circumstances in which the patient is discharged.	
ML106			A. The hospice shall immediately notify the patient or representative and shall include the date that the discontinuance is effective.	
ML107			B. Patient's/family's continuing care needs, if any, are assessed at discharge, and the patient/family are referred to appropriate resources.	Probe: Is there evidence of discharge planning and assessment of patient/family needs at discontinuance of hospice care?

ML108			4. The physician shall be notified in all instances of discontinuance of hospice care and such notification shall be documented in the patient record.	
ML109			**(E) General Provisions.** 1. A hospice shall maintain compliance with the standards in 19 CSR 30-35.010 and in 19 CSR 30-35.030. A hospice that operates a facility for hospice care shall also maintain compliance with 19 CSR 30-35.020.	
ML110			2. A hospice shall be primarily engaged in providing the care and services described in 19 CSR 30-35.010 and in 19 CSR 30-35.020 of this rule, and shall: A. Provide 24-hour nursing coverage for telephone consultation and visits as needed;	
ML111			B. Assure all other services that are reasonable and necessary for the palliation and management of terminal illness and related conditions are available on a 24-hour basis;	
ML112			C. Provide bereavement counseling; and	
ML113			D. Assure services are provided in a manner consistent with accepted standards of practice in accordance with local, state, and federal law.	
ML114			3. The hospice shall conduct criminal background checks in accordance with state law.	Refer to RSMo 660.317 and RSMo 210.900. Either method of background check will meet this regulation.
ML115			4. The hospice shall adhere to state and federal law relating to advance directives.	
ML116			**(F) Patient Rights.** The hospice shall have a written statement of patient rights which shall include, but need not be limited to, those specified herein.	
ML117			1. Each patient of a hospice program shall be informed in writing of his/her rights as recipients of hospice services.	
ML118			2. The hospice shall document that it has informed patients of their rights in writing and shall protect and promote the exercise of these rights.	
ML119			3. The patient's family, representative or guardian may exercise the patient's rights when all reasonable efforts to communicate with the patient have failed. These rights shall include:	
ML120			A. The patient and family's right for respect of property and person;	
ML121			B. The right to voice grievances regarding treatment or care that is, or fails to be, furnished or regarding lack of respect of property by anyone who is furnishing services on behalf of the hospice and the patient/family shall not be subjected to discrimination or reprisal for doing so;	
ML122			C. The right to be informed about his/her care alternatives available from the hospice and payment resources;	
ML123			D. The right to participate in the development of the plan of care and planning changes in the care;	
ML124			E. The right to be informed in advance about the care to be furnished;	
ML125			F. The right to be informed in advance of the disciplines that will furnish care and the frequency of visits proposed to be furnished;	
ML126			G. The right to be informed in advance of any change in the plan of care before the change is made;	
ML127			H. The right to confidentiality of the clinical records maintained by the hospice and to be informed of the hospice's policy for disclosure of clinical records;	
ML128			I. The right to be informed in writing of the extent to which payment	

			may be required from the patient and any changes in liability within 30 days of the hospice becoming aware of the new amount of the liability; and	
ML129			J. The right to access the Missouri home health and hospice toll-free hotline and to be informed of its telephone number, the hours of operations and its purpose for the receipt of complaints and questions regarding hospice services.	
ML130			**(G) Code of Ethics.** 1. A hospice shall develop a written code of ethics and have a process for reviewing ethical issues.	
ML131			**(H) 24-Hour Response.** 1. The hospice shall have written policies and procedures defining access to all services, medications, equipment and supplies during regular business hours, after hours and in emergency situations including a plan for prompt telephone response.	
ML132			2. Unscheduled non-emergent nursing visits when indicated should normally occur within three hours from the time the need is identified or as agreed upon by the hospice and patient.	
ML133			3. When clinically indicated, emergent visits shall be made within one hour from the time the need is identified.	Probe: How does the hospice determine emergent visits? Are there policies/guidelines for staff?
ML134			**(I) Infection Control.** The hospice shall identify person(s) responsible for implementing and monitoring an infection control program.	
ML135			1. The infection control program shall include a system for periodic review and update of infection control policies and procedures, a monitoring of practices and potential exposure to infection and of employee health and compliance with policies and procedures.	
ML136			2. The infection control policies and procedures shall conform with accepted standards of practice and address personal hygiene, aseptic and isolation techniques, waste disposal, and supply and medication storage.	
ML137			**(J) Safety and Emergency Preparedness.** 1. The hospice shall have safety and emergency preparedness plans that conform with federal, state and local requirements. Such plans shall include: A. A plan for reporting, monitoring and following up on all accidents, injuries and safety hazards; B. Documentation of monitoring activity and follow-up actions; and C. A safe and sanitary system for identifying, handling and disposing of hazardous wastes.	
ML138			D. The emergency preparedness plan shall be rehearsed at least annually.	Probe: Look for documentation that some component of the plan has been tested during the year. Examples include a documented review of a real event or rehearsal of a component of the plan.
ML139			**(K) Satellite/Branch Offices.** 1. If the hospice represents to the public that they have a satellite/branch office, there shall be: A. A designated interdisciplinary group with documented group meetings;	A. IDG does not need to be a separate group and may also serve other areas.
ML140			B. On-site maintenance of current active patient records; and	
ML141			C. Telephone reception during normal business hours.	
ML142			2. The satellite office must be located within 100 miles of the parent office.	
ML143			3. The standard of care and clinical services shall be the same out of the satellite/branch office as the parent office.	

ML144			**(2) Administration** **(A) Governing Body.** 1. A hospice shall have a governing body that assumes full legal responsibility for the hospice's total operation.	
ML145			2. The governing body shall meet, at a minimum, once a year.	Probe: Does the hospice have documentation to show the governing body meets once a year and appoints the administrator.
ML146			3. The governing body shall designate an administrator.	
ML147			**(B) Administrator Provisions.** 1. The administrator organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the interdisciplinary group(s) and the staff; employs qualified personnel; implements an effective budgeting and accounting system; and enforces written policies and procedures.	
ML148			2. A person shall be authorized to act in the absence of hospice administrator.	
ML149			3. A registered nurse coordinator shall be designated to direct the overall provisions of clinical services.	
ML150			**(C) Contracted Services.** 1. A hospice may arrange for another individual or entity to furnish services to the hospice's patients except as otherwise provided in these regulations. If services are provided under contract, the hospice shall meet the following standards:	Examples of contracted services may include: therapies, inpatient respite, DME, consulting physicians, acute inpatient.
ML151			A. Assure the continuity of patient/family care in home, outpatient and inpatient settings;	
ML152			B. Have a written agreement for the provision of contracted services. The agreement shall include the following: (I) Identification of the services to be provided in accordance with the plan of care; (II) The manner in which services are coordinated by the hospice to maintain hospice professional management responsibility; (III) Delineation of the role(s) of the hospice and the contracted services; (IV) Assurance that the contracted provider shall be appropriately licensed; (V) Provision for transfer and updating the plan of care on inpatient admission (if applicable).	(IV) Probe: How does the hospice assure appropriate licensing?
ML153			2. Such contracts shall not relieve the hospice of the primary responsibility for ensuring patient care or otherwise complying with these regulations.	
ML154			**(D) Plan of Care.** 1. A written plan of care must be established for each patient by the interdisciplinary group with the attending physician involvement.	Probe: Is there documentation to show that all members of the IDG established the plan of care? (See ML 167 for IDG members.)
ML155			2. The plan shall be established within seven days of admission.	
ML156			3. The care provided to a patient shall be in accordance with the plan.	
ML157			4. The plan shall include: A. Identification of the patient's/family's problems and needs; B. The scope and frequency of services needed to meet the patient's and family's needs and by whom the services will be provided, prescribed and required medical equipment, supplies, medications, treatments and the level of care; C. Realistic and achievable goals; and D. All physician orders.	

ML158			5. The plan shall be reviewed and updated by the interdisciplinary group at a minimum of every two weeks. These reviews shall be documented in the patient record.	Changes in the plan of care may be made by any IDG member; the entire IDG must review no less often than every two weeks.
ML159			6. Documentation on the plan of care shall reflect the changing needs of the patient/family and the services required to meet those needs.	Care plan updating should be an ongoing process reflecting the ongoing and changing needs of patient/family. Care plan updates need to occur at the time of the change. Examples of changes may include: Increase or decrease in visit frequency, addition or elimination of a new member of the IDG, adding a new medication, changes in the care setting, etc. Deficiencies may be written if needs are identified but not addressed in the plan of care.
ML160			**(E) Authorized Prescriber's Orders.** 1. Medications, treatments and procedures shall be administered only with an order by an authorized prescriber.	
ML161			2. Written orders shall be dated and signed at the time of writing.	
ML162			3. Oral orders, including authorization to use a standing order, shall be received only by persons authorized within their scope of practice, immediately reduced to writing, signed and dated by the person receiving the order and signed and dated by the prescriber within 30 days.	Note: This is not intended to require that the initiation of any previously signed standing order also requires an oral order; however, as stated in ML164, prescriber notification is still required after a standing order has been implemented.
ML163			4. A standing order may be used as part of the plan of care if the following guidelines are met: A. Standing orders shall be in compliance with all applicable state statutes and regulations and shall: (I) Include the purpose or conditions under which a standing order will be implemented; (II) Be drug, treatment or procedure specific and not allow for non-prescriber's choice; (III) Be individualized, signed and dated by the prescriber and included in the patient's record;	A.(II) Standing orders may not allow for nurses' choices of medications (including over-the-counter medications) or dosages.
ML164			B. Agency policy shall define the time frame for authorized prescriber notification when a standing order has been implemented; and	
ML165			C. Standing order content shall be reviewed and approved by the medical director at least annually.	
ML166			**F) Interdisciplinary Group.** 1. The hospice shall designate an interdisciplinary group or groups composed of qualified individuals who provide or supervise the care and services offered by the hospice. The interdisciplinary group shall meet no less often than every two weeks.	
ML167			2. The interdisciplinary group shall include at least the following individuals who are employees of the hospice: A. A doctor of medicine or osteopathy (may be contracted); B. A registered nurse; C. A social worker; and D. A spiritual counselor.	
ML168			3. The interdisciplinary group shall be responsible for: A. Participation in the establishment, review and updates of the plan of care; B. Provision or coordination of hospice care and services; and C. Making recommendations regarding policies governing the day-to-day	

			provision of hospice care and services.	
ML169			**G) Clinical Services.** The hospice shall routinely provide through direct employees the following services:	
ML170			**1. Nursing services.** A. Services shall be provided in accordance with recognized standards of practice.	
ML171			B. Nursing services shall be staffed to assure that the nursing needs of patients are met.	
ML172			C. The assessment, planning and provision of nursing services shall be the responsibility of the registered nurse.	
ML173			D. When nursing services are delegated to a licensed practical nurse: (I) The licensed practical nurse shall be supervised by a registered nurse who is available to the licensed practical nurse at least by phone during the hours that the licensed practical nurse is providing services or is on call; and	
ML174			(II) The registered nurse shall make at least monthly on-site visits and document that the licensed practical nurse is routinely providing nursing services in accordance with the plan of care.	
ML175			E. The registered nurse shall develop a written aide assignment based upon the patient's/family's needs when home health aide services are provided.	
ML176			F. When aide services are being provided, a hospice registered nurse shall visit the home at least every two weeks. The visit shall include an assessment of the aide services.	
ML177			G. Written documentation shall show that the aide is providing services in accordance with the plan of care.	
ML178			H. When an aide is permanently assigned to a hospice facility, the every two-week supervisory requirement does not apply, however there must be evidence of an annual performance review in the aide's personnel file.	This applies to a licensed hospice inpatient facility.
ML179			**2. Medical director services.** The medical director shall be a direct or contract employee. The medical director's or designee's services and responsibilities include:	
ML180			A. Consulting with attending physicians regarding pain and symptom control;	
ML181			B. Reviewing patient appropriateness for hospice services;	
ML182			C. Acting as medical resource for the interdisciplinary group;	
ML183			D. Acting as liaison to physicians in the community;	
ML184			E. Assuring medical services are provided in the event the medical needs of the patient are not met by the attending physician; and	
ML185			F. Routinely attending the interdisciplinary group meetings.	
ML186			**3. Medical social services.** A. Medical social services shall be provided in accordance with recognized Standards of practice.	
ML187			B. Social services shall be staffed to assure that the medical social service needs of patients are met.	
ML188			C. The assessment, planning and provision of medical social services shall be the responsibility of the social worker.	
ML189			D. The social services assessment visit shall be completed within seven	

			days of admission or sooner if indicated.
ML190			**4. Spiritual care services.** A. Spiritual care shall be available to all patients and families.
ML191			B. The spiritual counselor is responsible for assuring there is a documented assessment of the spiritual needs of the patient and family within seven days of admission and that spiritual care provided reflects assessed needs.
ML192			C. The spiritual assessment shall include, at a minimum: (I) The identification of any religious affiliation the patient and family may have; and (II) The nature and scope of any spiritual concerns or needs identified.
ML193			D. A visit by the spiritual counselor shall be offered to each patient. If the patient declines spiritual counselor visits, the spiritual counselor will serve as a resource for other interdisciplinary team members assessing spiritual needs and providing care, and will be available to coordinate with other spiritual care providers the patient/family may have identified.
ML194			**5. Bereavement care services.** A. There shall be an organized program for the provision of bereavement services under the supervision of a qualified professional who is a person with training or experience related to death, dying and

The definition establishes two alternate routes for demonstrating competency to function as a spiritual counselor.

In addition to the general requirement stipulated above, the spiritual counselor must either:

- Have completed, or complete by August 1, 2003, one unit of Clinical Pastoral Education (CPE);

Or

- Have a minimum of a bachelor's degree with emphasis in counseling or related subjects; and
- Within ninety days of hire, have completed specific training to include:
  - common spiritual issues in death and dying;
  - belief systems of comparative religions related to death and dying;
  - spiritual assessment skills;
  - individualizing care to patient beliefs;
  - and varied spiritual counselor's personnel file.

The surveyor will expect to see documentation demonstrating compliance with this definition in the spiritual counselor's personnel file.

Persons who carry out assigned spiritual care tasks, under the supervision of the spiritual counselor and/or volunteer coordinator (e.g., visiting the patient to read scripture, offer prayer, etc.) are not considered spiritual counselors, and do not have to meet the requirements of this definition. Such persons may not conduct the documented assessment identifying those needs unless they conform to all elements in the spiritual counselor definition.

Probe: The spiritual assessment will normally be done by the spiritual counselor unless the patient/caregiver declines spiritual counselor visits. In these instances the spiritual counselor will assure that another interdisciplinary team member conducts and documents a spiritual assessment that, at a minimum includes the elements in ML 192.

			bereavement.
ML195			B. Within two months following the patient's death, there shall be an assessment of risk of the bereaved individual and a plan of care that extends for one year appropriate to the level of risk assessed.
ML196			C. In addition to the assessment, at least one bereavement visit (other than funeral attendance/visitation) shall occur within six months after the death of the patient.
ML197			**6. Other clinical services.** The hospice shall provide the following services directly by hospice employees or through a contracted provider. The assessment, planning and provision of these services shall be the responsibility of the applicable licensed or registered clinician.
ML198			A. Dietary counseling, when required, shall be planned by a qualified dietary counselor.
ML199			B. Physical therapy services, occupational therapy services, and speech language pathology services shall be offered in a manner consistent with accepted standards of practice.
ML200			(I) Therapy services delegated to the physical therapy assistant or the occupational therapy assistant shall be supervised by a licensed physical therapist or registered occupational therapist as appropriate who is available to the physical therapy assistant or occupational therapy assistant at least by phone during the hours that she/he is providing services.
ML201			(II) When the assistant is providing services to a patient, the licensed or registered therapist shall make a supervisory visit to the residence of the patient at least every 30 days.
ML202			(III) Written documentation shall show that the assistant is providing therapy services in accordance with the plan of care.
ML203			**C. Additional counseling services.** Any additional counseling services provided by the hospice shall be provided by qualified personnel, coordinated with all hospice services, included in the plan of care and documented in the clinical record.
ML204			**D. Waiver.** (I) These requirements shall be waived by the Department of Health for areas of the state in which no licensed therapists/dietitians/nutritionists are available provided a good faith effort to provide the service is being made.
ML205			(II) A hospice seeking this waiver shall submit a written request to the department along with evidence of efforts made by the hospice to provide the service. If approved, a request for waiver shall be resubmitted annually for review.
ML206			**7. Home health aide and homemaker services.** Home health aide and homemaker services shall be available to meet the needs of the patients.
ML207			A. If homemaker needs are identified, a member of the interdisciplinary group shall assign and coordinate the services.
ML208			B. Home health aide services must be provided by a qualified person as set forth in 19 CSR 30-35.010(1)(A)10.
ML209			C. A home health aide is not considered to have completed a training and competency program, or a competency evaluation program if, since the individual's most recent completion of such program(s), there has

Probe: Is there evidence that the need for homemaker services has been evaluated?

			been a continuous period of 24 consecutive months during none of which the individual furnished services described in 42 CFR 409.40 for compensation.
ML210			D. The home health aide shall follow written instructions for patient care which are prepared by a registered nurse and document care provided. Duties include, but shall not be limited to, the duties specified in the regulations pertaining to the Medicare home health aide (42 CFR 484.36).
ML211			E. 12 hours of in-service per aide per 12-month period shall be provided or assured by the hospice. The hospice shall maintain a record of in-service provided.
ML212			**(H) Medications.** The hospice shall develop policies and procedures for the safe and effective use of medications, in accordance with accepted professional standards and applicable laws and regulations.
ML213			1. A medication list shall be maintained for each patient.
ML214			2. Medication orders shall include the medication name, dose, frequency and route of administration.
ML215			3. Orders with variable doses or frequencies shall specify a maximum dose or frequency and the reason for administration.
ML216			4. Medications shall be provided on a timely basis and medication services shall be available on a 24-hour basis for emergencies.
ML217			5. When controlled substance medications are delivered to the patient's residence by hospice staff, the date, patient name, medication name and strength, quantity indicated on the prescription container, and signatures of the hospice staff member and the receiver shall be documented.
ML218			6. The hospice shall identify and document any misuse of controlled substances and shall notify the prescriber.
ML219			7. Medication use shall be reviewed with the patient, family or both and medication information, counseling and education shall be provided when appropriate.
ML220			8. Current medication reference material shall be available to professional staff for all medications used.
ML221			9. Medications shall be administered by persons who have statutory authorization, the patient, or a family member.
ML222			10. Administration by the patient or by a family member shall be evaluated for appropriateness and ability and this evaluation documented by the nurse.
ML223			11. Medication incidents, including medication errors and adverse medication reactions, shall be reported to the prescriber, the registered nurse coordinator and the pharmacist.
ML224			12. The hospice must have a policy for the disposal of controlled substances maintained in the patient's home when those medications are no longer needed by the patient. The policy shall include at a minimum, information shared with family regarding disposition of medications when no longer required.
ML225			13. Meds shall not be transferred to other patients and shall not be removed from the residence by hospice staff.
ML226			**(I) Medical Supplies and Equipment.** 1. The provision of medical supplies and equipment shall be coordinated as needed for the palliation and management of the terminal illness and

Is there clear documentation that the patient or caregiver has been evaluated for medication administration?

Is there a process to deal with medication incidents?

			related conditions. Hospices shall make every effort to assure that patient needs for medical supplies and equipment are met.
ML227			2. Hospice shall provide education for patient/family, employees and volunteers on the safe use of medical equipment.
ML228			3. Hospice shall provide evidence that all hospice-owned patient care related equipment has been inspected and maintained on an annual basis and in accordance with manufacturers specifications.
ML229			4. Hospice shall have policies and procedures for cleaning, storing, accessing and distributing hospice-owned equipment.
ML230			5. Supplies shall be stored and maintained in a clean and proper manner.
ML231			**(J) Volunteers.** 1. Each hospice shall document and maintain a volunteer staff sufficient to provide administrative and direct patient care hours in an amount that, at a minimum, equals five percent of the total patient care hours of all paid hospice employees and contract staff. The hospice shall document a continuing level of volunteer activity.
ML232			2. Care and services through the use of volunteers, including the type of services and the time worked, shall be recorded.
ML233			3. The hospice shall document initial screening and active and ongoing efforts to recruit and retain volunteers.
ML234			4. The hospice shall provide task-appropriate orientation and training consistent with acceptable standards of hospice practice, that includes at a minimum: A. Hospice philosophy, goals and services; B. The volunteer role in hospice; C. Confidentiality; D. Instruction in the volunteer's particular duties and responsibilities; E. Whom to contact if in need of assistance or instruction regarding the performance of their specific duties and responsibilities; and F. Documentation and record keeping as related to the volunteer's duties.
ML235			5. The hospice shall, in addition, provide orientation for patient care volunteers that includes at a minimum: A. Concepts of death and dying; B. Communication skills; C. Care and comfort measures; D. Psychosocial and spiritual issues related to death and dying; E. The concept of hospice patient and family as the unit of care; F. Procedures to be followed in an emergency or following the death of the patient; G. Concepts of grief and loss; H. Universal precautions; I. Safety; J. Patient/family rights; and K. Hospice and the nursing home.
ML236			6. The hospice shall document orientation and ongoing in-services.
ML237			7. Volunteers functioning in accordance with professional practice acts must show evidence of current professional standing and licensure, if applicable.
ML238			**(K) Central Clinical Records.** 1. In accordance with accepted principles of practice, the hospice shall establish and maintain a clinical record for every patient receiving care

Divide total number of volunteer hours, including administrative, direct patient care and training hours by the number of paid patient care hours.

Note: Volunteers are required to have criminal background checks and health screenings as required for other patient care personnel.

			and services.
ML239			2. The record shall be complete, legible, readily accessible and systematically organized to facilitate retrieval. Documentation shall be prompt and accurate.
ML240			3. Each clinical record shall be a comprehensive compilation of information. Entries shall be made for all services provided.
ML241			4. Entries shall be made and signed by the person providing the services.
ML242			5. The record shall include all services whether furnished directly or through contracted providers. Each clinical record shall contain:
ML243			A. Physician's orders;
ML244			B. Complete documentation of all assessments, services and events including: (I) The physical condition of the patient; (II) The psychosocial status of the patient/family; (III) The spiritual status of the patient/family; and (IV) Potential bereavement complications;
ML245			C. The plan of care;
ML246			D. Identification data;
ML247			E. Consent form;
ML248			F. Pertinent medical history;
ML249			G. Determination of financial responsibility; and
ML250			H. Documentation of communication with coordinating providers.
ML251			6. The hospice shall safeguard the clinical record against loss, destruction and unauthorized use.
ML252			**(L) Facility Resident.** 1. When the hospice patient resides in a nursing facility, the hospice collaborates with the nursing facility providing care to the patient/family to ensure coordination of services.
ML253			2. Collaboration activities shall include the following: A. There shall be a coordinated single plan of care in the nursing facility which may be multiple documents, that: (I) Reflects coordination and input from both the hospice and the nursing facility; (II) Identifies the care and services which each shall provide; and (III) Is updated to reflect changes in patient/family condition, needs and care.
ML254			B. Services usually identified as hospice services shall remain the responsibility of the hospice, and are provided or arranged by the hospice to meet the needs of the patient at the same level that the hospice normally furnishes to patients in their homes.
ML255			C. A registered nurse is designated from the hospice to coordinate the implementation of the plan of care, and to respond to questions and concerns from the nursing facility.
ML256			D. The hospice shall provide education to nursing facility staff that includes at a minimum: (I) The purpose and nature of hospice care; (II) Services provided by the hospice; (III) Care plan coordination; (IV) When and how to contact hospice staff.
ML257			3. The hospice shall document education provided and/or education offered and declined by the nursing home.

Assure that the hospice has neither over nor underdelegated care.

ML258			4. The hospice shall enter into arrangements only with nursing facilities which are appropriately licensed.
ML259			**(M) Employee Training and Orientation.** 1. Each hospice shall provide initial orientation for each direct employee that is specific to the employee's job duties.
ML260			A. All employees shall be oriented to: (I) Hospice philosophy, goals and services; (II) Confidentiality; (III) Specific job duties; (IV) Hospice policies and procedures as appropriate to the position.
ML261			B. Patient care employees shall also be oriented to: (I) Interdisciplinary group function and responsibility; (II) Communication skills; (III) Physical, psychosocial and spiritual assessment; (IV) Plan of care; (V) Symptom management; (VI) Universal precautions; (VII) Patient/family safety issues; (VIII) Patient/family rights; (IX) Documentation; (X) Concepts of grief and loss; (XI) Facility resident care; and (XII) Levels of hospice care.
ML262			C. Ongoing in-service training shall include a broad range of topics that reflect identified educational needs.
ML263			D. The hospice shall document initial orientation and in-service topics presented.
ML264			2. Volunteers are exempt from these provisions as their orientation and in-service requirements are defined in 19 CSR 30-35.010(2)(J)4., 5. and 6.
ML265			3. Contract personnel shall receive orientation to confidentiality, hospice philosophy, and to their specific job duties.
ML266			**(N) Performance Improvement.** 1. The hospice shall follow a written plan for assessing and improving program operations which includes: A. Goals and objectives; B. The identity of the person responsible for the program; and C. A method for resolving identified problems.
ML267			2. The plan and performance improvement activities shall be reviewed at least annually by a designated group and the governing body and revised as appropriate.
ML268			3. When problems are identified in the provision of hospice services, the hospice shall document any evidence of corrective actions taken, including ongoing monitoring, revisions of policies and procedures, educational intervention, and changes in the provision of services.
ML269			4. The effectiveness of actions taken to improve services or correct identified problems shall be evaluated.
ML270			5. A designated group shall review and document the performance improvement activities and monitor corrective actions.
			19 CSR 30-35.020 Hospice Providing Direct Care in a Hospice Facility

ML301			(1) A hospice that delivers care in a facility operated by the hospice and not otherwise licensed shall comply with this rule in addition to 19 CSR 30-35.010 and 19 CSR 30-35.030.
ML302			(2) Each patient shall receive treatment, medications and diet as prescribed and shall be kept comfortable, clean, well-groomed and protected from accident, injury and infection.
ML303			**(3) Organization and Management of Hospice Facilities.** **(A) 24-Hour Staffing.** 1. The hospice shall provide 24-hour staffing which is sufficient to meet the patients' total needs in accordance with the patient plan of care.
ML304			2. All hospices shall employ qualified staff at the ratio of no less than one for every ten (1:10) patients per shift, per patient unit, 24 hours a day.
ML305			3. Staffing personnel shall be on duty at all times on each patient-occupied floor, with no less than two staff personnel in a facility at all times.
ML306			4. Minimum staff personnel shall be no less qualified than one home health aide or companion/volunteer and one licensed practical nurse.
ML307			5. A registered nurse shall be available for telephone consultation or on-site visit as needed, 24 hours a day.
ML308			6. Facility personnel shall have a telephone access to administrative staff, 24 hours a day.
ML309			**(B) Disaster Preparedness.** 1. The hospice shall have a written plan, annually rehearsed with staff, which includes procedures to be followed in the event of an internal or external disaster and for the care of casualties arising from disasters.
ML310			2. Each facility shall conduct quarterly fire drills so that each shift participates at least annually.
ML311			**(C) Meals Service Menu Planning and Supervision.** The hospice shall: 1. Make available a practical freedom of choice diet offering at least three meals and snacks, or their equivalent, that accommodate patient's needs and preferences each day at regular times, with not more than 14 hours between a substantial evening meal and breakfast;
ML312			2. Prepare and serve foods using methods that conserve nutritive value, flavor and appearance;
ML313			3. Give special attention to the texture of food served to patients who have chewing difficulty;
ML314			4. Provide assurance that hot food is served hot and cold food is served cold;
ML315			5. Give a minimum of 30 minutes for eating meals. Patients who eat slowly or who need assistance shall be given as much time to eat as necessary;
ML316			6. Make tray service and dining room service attractive for patients and ensure that each patient receives appropriate table service;
ML317			7. Provide each patient who is served meals in bed or in a chair not within the dining area with either a table, an overbed table or an overbed tray of sturdy construction which is positioned so that the patient can eat comfortably;
ML318			8. Provide assistance upon tray delivery to all patients requiring assistance at mealtimes, whether it be preparation of the food items or actual feeding. Dining room supervision shall be provided during meals;
ML319			9. Establish an identification system to assure that each patient receives the diet as ordered;
ML320			10. Provide sufficient equipment and personnel trained in their duties to

			assure adequate preparation and serving of food if meals are prepared on-site;
ML321			11. Review menus for special prescribed diets and approve in writing by either a qualified dietitian, a registered nurse, or a physician;
ML322			12. Keep a current record of purchased food to show the kind and amount of food purchased each month, if meals are prepared on-site;
ML323			13. Plan menus for all diets at least two weeks in advance if meals are prepared on-site. If cycle menus are used, the cycle shall cover a minimum of three weeks and shall be different each day of the week;
ML324			14. Make fresh water readily accessible to all patients at all times;
ML325			15. Procure, store, prepare, distribute and serve all food under sanitary conditions;
ML326			16. Permit family to bring, prepare and serve food to their loved one; and
ML327			17. Permit staff to prepare a single patient snack upon request.
ML328			**(D) Patient Areas.** 1. The hospice shall design and equip areas for the comfort and privacy of each patient and family member.
ML329			2. The hospice shall have accommodations for family privacy after a patient's death that do not infringe on other patients' rights and decor which is homelike in design and function;
ML330			3. Patients shall be permitted to receive visitors, including small children, at any hour;
ML331			4. The facility shall have a policy regarding pets; and
ML332			5. Smoking may be permitted in the hospice consistent with the smoking policy of the facility. Smoking may be permitted in the patient's room and in designated smoking areas. Individual patients may be permitted to smoke in their rooms with the consent of any other patients occupying the room and with the permission of his/her attending physician. If a patient is confined to bed or classified as not being responsible, smoking is permitted only under the direct supervision of an authorized individual.
ML333			**(E) Infection Control.** 1. The hospice shall make disease-specific provision for isolating patients with infectious diseases.
ML334			2. Infectious waste management control. A. Every inpatient hospice facility shall write an infectious waste management plan with an annual review identifying infectious waste generated on-site, the scope of the infectious waste program and policies and procedures to implement the infectious waste program. The plan shall include at the least the following: administrator's endorsement letter; introduction and purpose; objectives; phone number of responsible individuals; definition of those wastes handled by the facility; identification of responsible individuals; procedures for waste identification, segregation, containment, transport, treatment and disposal; emergency and contingency procedures and training; and educational procedures.
ML335			B. Infectious waste shall be segregated from other wastes at the point of generation and shall be placed in distinctive, clearly marked, leakproof containers or plastic bags appropriate for the characteristics of the infectious waste.
ML336			C. Containers for infectious waste shall be identified with the universal biological waste symbol. All packaging shall maintain its integrity during storage and transport. Infectious waste shall not be placed in a

			gravity disposal chute.	
ML337			D. Pending disposal, infectious waste shall be stored separately from other wastes in a room limited to staff access.	
ML338			E. When transported off the premises of the hospice, all infectious waste shall be packaged and transported as provided in sections 260.200–260.245, RSMo.	Rigid, puncture proof containers and labeled.
ML339			F. Hospices generating 100 kilograms or less of infectious waste per month must comply with section 260.203.10, RSMo.	
ML340			3. Written policies and procedures shall define and describe the scope and conduct of laundry and linen services. There shall be a mechanism for the review and evaluation on an annual basis of the quality of laundry services.	
ML341			4. Written policies and procedures shall define and describe the scope and conduct of on-site cleaning of dietary ware. There shall be a mechanism for the review and evaluation on an annual basis of the quality of dietary-ware sanitizing services provided.	
ML342			**(F) Pharmacy Services.** The hospice shall comply with all provisions of 19 CSR 30-35.010 regarding medications.	ML212-225 – please reference
ML343			**1. The hospice shall employ or contract with a pharmacist.**	
ML344			A. The pharmacist shall assist in the development of policies and procedures for medication use, shall advise the hospice on all other matters pertaining to the use of medications, shall serve as a member of, or consultant to, the interdisciplinary team and shall provide medication information to professional staff as required.	
ML345			B. Pharmacist shall be available on a 24-hour basis for emergencies.	
ML346			**2. Medication acquisition and labeling.** A. No stock supply of prescription medications shall be maintained except that each facility shall maintain an emergency medication kit and controlled substances may be maintained as stock.	
ML347			B. When the emergency medication kit contains controlled substances the facility shall be registered with the Missouri Bureau of Narcotics and Dangerous Drugs.	
ML348			C. When controlled substances are maintained in stock, the facility shall be registered with the Missouri Bureau of Narcotics and Dangerous Drugs and the Drug Enforcement Administration.	
ML349			D. Patient prescription medications shall be labeled with at least the patient name, medication name, strength and date dispensed. They shall also contain accessory information and the expiration date when applicable.	
ML350			E. Prescription medication labels shall not be altered by hospice staff and medications shall not be repackaged by hospice staff except as allowed by (3)(F)4.E.	
ML351			F. When the patient's own medications are used, they shall be examined prior to use for suitability and positively identified by a pharmacist or nurse in writing.	
ML352			G. Non-prescription medications may be obtained as stock or individual patient supplies. They shall not be repackaged, except as allowed by (3)(F)4.E., and supplies for individual patients shall be labeled with the patient's name.	
ML353			**3. Medication storage and control.** A. All medications shall be stored in locked compartments under proper	

			temperature controls, separate from food and other substances, and accessible only to persons authorized to administer them.	
ML354			B. Controlled substances shall be stored in locked compartments separate from other medications.	
ML355			C. The pharmacist shall inspect medication storage areas and the emergency medication kit monthly and shall document this inspection.	
ML356			D. Records of receipt and disposition of all controlled substances shall be maintained separate from other records.	
ML357			(I) Inventories of Schedule II controlled substances shall be reconciled each shift.	
ML358			(II) Inventories of Schedule III–V controlled substances shall be reconciled daily.	
ML359			(III) Receipt records shall include the date, source of supply, patient name and prescription number when applicable, medication name and strength, quantity and signatures of the supplier and receiver.	
ML360			(IV) Administration records shall include the date, time, patient name, medication name, dose administered and signature of the person administering.	
ML361			(V) Documentation of waste at the time of administration shall also include the reason for the waste and the signature of an authorized employee witness.	
ML362			E. The pharmacist shall review controlled substance record keeping monthly.	
ML363			F. All variances of controlled substance records shall be reported to the registered nurse coordinator and the pharmacist for review and investigation.	
ML364			G. All losses of controlled substances shall be reported to the Missouri Bureau of Narcotics and Dangerous Drugs and to other federal, state and local authorities when required.	
ML365			H. All controlled substance records shall be maintained for two years.	
ML366			**4. Medication administration.** A. Medication administration by the patient or a family member shall be ordered by the physician. Instructions for administration shall be provided.	ML366-ML369 - Patient/family and nurse need keys.
ML367			B. Non-controlled substances may be stored in a locked compartment in the patient's room.	
ML368			C. Single doses of controlled substances may be placed in the locked compartment or provided directly to the patient or family member prior to the time of administration.	
ML369			D. Administration of the patient's own medications brought to the facility shall be ordered by the authorized prescriber.	Need physician order.
ML370			E. Medications for administration when a patient temporarily leaves the facility shall be labeled by the pharmacy with instructions for administration, except that a single dose of each medication may be provided by the nurse in containers labeled with the patient's name, medication name and strength, instructions for administration, and other necessary information.	
ML371			F. Medication administration shall be documented on a separate record. Administration by the patient or a family member shall be monitored by nursing staff and documented.	
ML372			**5. Other medication disposition.** A. Medications may be sent with a patient at the time of discharge only if	Need order from physician to continue prescription at home.

			they have been labeled by the dispensing pharmacy with instructions for administration and ordered by the authorized prescriber.
ML373			B. Records of this disposition shall include the date, patient name, prescription number, drug name and strength, quantity and signatures of the persons releasing and receiving the medications.
ML374			C. Patient prescription medications that have been discontinued shall be destroyed within 60 days if they are controlled substances or if they are not in unit-dose packaging.
ML375			D. Patient prescription medications of expired patients shall be destroyed within five days if they are controlled substances or if they are not in unit-dose packaging or if they were brought from home.
ML376			E. Other expired or nonusable medications shall be destroyed within five days.
ML377			F. Medications shall be destroyed by a pharmacist and a nurse or two nurses, and a record of destruction shall be maintained which includes the date, patient name, prescription number, medication name and s strength, quantity, method of destruction and signatures of the persons destroying the medications.
ML378			G. Unit-dose packaged medications returnable to the pharmacy shall be returned within ten days.
ML379			H. Medications shall not be transferred to other patients and shall not be removed from the facility by hospice staff, except those being returned to the pharmacy.
ML380			**(4) General Design and Construction Standards for New Inpatient Hospice Facilities.** **(A) Health and Safety Laws.** The hospice shall meet all federal, state and local laws, ordinances, regulations and codes pertaining to health and safety, including but not limited to, provisions regulating construction, maintenance and equipment.
ML381			**1. General Requirements.** A. After October 30, 1996, a new hospice facility shall submit plans for approval to the Department of Health for the construction of a new facility, expansion or renovation of an existing state certified hospice or the conversion of an existing facility not previously and continuously state certified and operated as a hospice facility under section 197.250, RSMo.
ML382			B. New hospice facilities shall be designed and constructed in conformance with this rule.
ML383			C. This rule is not intended to restrict innovations and improvements in design or construction techniques. Accordingly, the Department of Health may approve plans and specifications which contain deviations from this rule. Requests for deviations from requirements on physical facilities shall be in writing to the Department of Health and shall contain information which determines that the respective intent or objectives of this rule have been met. Approvals for deviations shall be in writing and both requests and approvals shall be made a part of the permanent Department of Health records for the hospice.
ML384			D. Where renovation or replacement work is done within an existing licensed facility, all new work, additions, or both, shall comply with the applicable sections of this rule. Where existing major structural elements make total compliance impractical or

			impossible, alternative proposals which result in an equivalency may be considered by the department.
ML385			E. In renovation projects and additions to existing state certified hospice facilities, only that portion of the total facility affected by the project shall comply with the applicable sections of this rule. However, upon construction completion, the facility shall satisfy all functional requirements for state certified hospices.
ML386			F. Those existing portions of the facility which are not included in the renovation but which are essential to the functioning of the complete facility as well as existing state certified building areas that receive less than substantial amounts of new work shall, at a minimum, comply with the state certification requirements which were in effect at the time that the existing portion of the building was state certified.
ML387			G. All required fire exits shall be maintained throughout the construction and the work shall be phased as necessary to minimize disruption of the existing hospice operation.
ML388			**2. Planning and Construction Procedures.** A. Any hospice facility constructed or renovated after October 30, 1996 shall have plans and specifications prepared in conformance with Chapter 327, RSMo by an architect or engineer duly registered in Missouri. The owner of each new facility or the owner of an existing licensed inpatient hospice being added to or undergoing major alterations shall provide a program—scope of services—which describes space requirements, staffing patterns, departmental relationships and other basic information relating to the objectives of the facility. The program may be general but it shall include a description of each function to be performed, approximate space needed for these functions and the interrelationship of various functions and spaces. The program shall describe how essential services can be expanded in the future as the demand increases. Appropriate modifications or deletions in space requirements may be made when services are shared or purchased, provided the program indicates where the services are available and how they are to be provided. This program shall be submitted to the Department of Health for review along with the plans developed for the project. Schematic and preliminary plans showing the basic layout of the building and the general types of construction, mechanical and electrical systems and details may be submitted to the department before the larger and more complicated working drawings and specifications so that necessary corrections can be easily made before final plans are completed. Working drawings and specifications, complete in all respects, shall be prepared and submitted to the Department of Health for approval. These plans shall cover all phases of the construction project, including site preparation: paving; general construction; mechanical work, including plumbing, heating, ventilating and air conditioning; electrical work; and all built-in equipment, including elevators, kitchen equipment, cabinet work, and the like.
ML389			B. The Department of Health shall be notified in writing within five days after construction begins.
ML390			Construction shall be in conformance with plans and

			specifications approved by the Department of Health. The department may elect to inspect the construction of hospice projects at any time during the development of the project.
ML391			If construction of the project is not started within one year or completed within a period of three years after the date of the approval of the plans and specifications, the plans and specifications shall be resubmitted to the Department of Health for its approval and shall be amended, if necessary, to comply with the then current rules before construction work is started or continued.
ML392			C. References in this rule to National Fire Protection Association (NFPA) publications are those contained in the 12-volume *1994 Compilation of NFPA Codes, Standards, Recommended Practices and Guides*. Where there are discrepancies between referenced NFPA publication requirements and this rule, the requirements of this rule shall apply.
ML393			D. The design and construction of hospices shall conform to the most stringent requirements of this rule and the local governing building code and zoning ordinances.
ML394			**3. Site.** A. Adequate paved pedestrian access shall be provided within the lot lines to the main entrance. Loading and unloading space for delivery vehicles shall be paved.
ML395			B. Adequate paved parking shall be provided. Parking space needs shall be determined by the local zoning requirement and the operational program but shall not be less than one space for each of the maximum number of staff persons on duty at any given time plus one parking space for each licensed inpatient bed in the facility.
ML396			C. Fire lanes shall be provided as required by local authority and kept clear to provide immediate access for fire fighting equipment.
ML397			D. The site shall provide reasonable access for those individuals to be served by the facility. The facility shall be on an all-weather road for easy access by vehicular traffic. Consideration should be given to locating the hospice to provide easy access to public transportation services which may be available in the community.
ML398			E. The site shall be located within the service area of a public fire department.
ML399			**4. Roads, parking facilities, walks, ramps and entrances shall be accessible and usable by persons with various physical handicaps.**
ML400			A. At least one toilet, telephone and drinking fountain shall be provided on each floor of a hospice which is accessible for use by handicapped public and staff.
ML401			B. Elevator controls and alarms shall be accessible to wheelchair occupants and shall be provided with tactile signage for the visually impaired.
ML402			C. Design details for handicapped accessible facilities should be consistent with the *Guidebook to: The Minimum Federal Guidelines of Requirements for Accessible Design* published January 6, 1981, by the U.S. Architectural and Transportation Barriers Compliance Board.

ML403			D. At least ten percent of the patient beds shall be located in handicapped-accessible rooms with accessible toilet rooms which open directly into the patient room. All other clinical areas to which patients have common access shall be handicapped-accessible.
ML404			**5. Administrative and public areas shall be provided.** A. All hospices shall provide adequate work areas to support the administrative personnel and governing body. The facilities shall allow business to be conducted in a setting which provides confidentiality and privacy as required. The administrative offices may be located remotely from a hospice inpatient unit or may be housed within the inpatient facility.
ML405			B. Where administration is included within the inpatient facility, the following shall be provided: (I) Administrator's office; (II) Business office including a work area for quality assurance; (III) Storage and work area for archived medical records; (IV) Conference room for governing board meetings and personnel in-service training; and (V) Office for director of patient-care services.
ML406			C. Each inpatient hospice facility shall provide the following public areas in a location separated from the clinical and service areas of the facility: (I) Lobby/waiting room with reception; (II) Wheelchair accessible public toilet; (III) Wheelchair accessible public drinking fountain; and (IV) Wheelchair accessible public phone.
ML407			**6. Design of patient-care units.** A. One or more patient-care units shall be provided. Each unit shall not exceed a maximum of 20 beds.
ML408			B. Each patient-care unit shall be a continuous area which does not require patient-care traffic to traverse other areas and shall be restricted to only one floor level. If justified by the program submitted under subparagraph (2)(A)2.A. of this rule, the department may consider approval of designs which provide for larger capacity patient- care units.
ML409			C. The bed area in a patient room exclusive of toilet rooms, closets, alcoves or vestibules, shall not be less than 120 square feet in a private room and not less than 200 square feet in a semi-private room. Heating units and lavatories may protrude into this space.
ML410			D. No dimension for the bed area in any patient room shall be less than ten feet.
ML411			E. No patient room shall house more than two patients.
ML412			F. Each patient-care unit shall have not greater than 50% of its beds housed in semi-private rooms and the remaining rooms shall be limited to occupancy by one patient. If justified by the program submitted under subparagraph (2)(A)2.A. of this rule, the department may consider approval of designs which provide other ratios of semi-private to private patient rooms.
ML413			G. Each patient shall have access to a toilet room without entering the general corridor area.
ML414			H. One toilet may serve not more than two adjacent rooms.
ML415			I. The toilet room shall contain a lavatory and water closet and shall be

			sized to permit access for the patient and an assisting member of the staff. The lavatory may be omitted from the toilet room if a lavatory is provided in the patient room.
ML416			J. At least one patient room per patient-care unit shall be provided to be used for isolation. This unit shall have a toilet room equipped with a bathing facility which serves this room exclusively.
ML417			K. Mirrors shall be provided in each patient room or adjoining toilet room. Mirrors shall be at least three feet high located with the bottom edge no more than three feet four inches above the floor.
ML418			L. Patients shall have separate wardrobes, lockers or closets located within their respective patient rooms. A clothes rod and shelf shall be provided.
ML419			M. One or more windows shall be provided, with the sash not more than three feet above the floor and with a gross area of not less than ten percent of the floor area of the room. In each patient room at least one window to the outside shall be operable. Patient room windows shall be exposed to an outside area not less than 30 feet horizontally opposite the window which contains no construction or grading which would further diminish the view and the exposure of the window to natural light.
ML420			N. Social spaces (dining, recreation, meditation) shall be provided throughout the facility with a cumulative area of not less than 30 square feet per patient bed. One social space may serve more than one patient-care unit provided it is directly accessible from each unit and is sized proportionate to the total number of patient beds it serves. No social space shall be smaller than 150 square feet in area.
ML421			O. Unless bathing facilities are included in the toilets serving each patient room, central bathing facilities shall be provided in each patient-care unit at a ratio of not fewer than one for each ten (1:10) beds.
ML422			P. Each bathing facility shall be located in its own room and shall be directly accessible from the general corridor. The bathing facility may be either a tub, shower or tub/shower combination.
ML423			Q. However, at least one handicapped accessible shower shall be provided on each patient unit.
ML424			R. A locked cabinet for the storage of cleaning supplies shall be available in or near each bathroom.
ML425			**7. Support and services areas.** The following staff support and service areas shall be located directly accessible to each patient care unit:
ML426			A. Clean work and storage facilities shall be equipped with counter and sink and storage space provided for clean linen and supplies;
ML427			B. A separate soiled/decontamination utility room shall be equipped with a clinic sink (this fixture is not required where bedpan-flushing devices have been installed at each patient toilet), counter and sink and sufficient floor space shall be provided to accommodate storage containers for soiled linen, trash and infectious waste;
ML428			C. Space shall be provided for secure storage of staff personal items;
ML429			D. A staff station shall be located to provide visual supervision of the patient-care unit corridors. The station shall consist of a work counter and secure storage space for charts;

ML430			E. A medication storage and preparation station which has a means of locked storage for all medications shall be equipped with a work counter, sink, and refrigerator;
ML431			F. Separate locked storage facilities shall be provided in the station for controlled substances;
ML432			G. If medications are held in each patient room, the room shall include separate locked storage facilities for each patient's medications;
ML433			H. A nourishment station shall be equipped with a work counter, sink, and refrigerator and shall be provided physically remote from the medication preparation station;
ML434			I. Storage space shall be provided for mobile equipment used on the unit;
ML435			J. A janitor's closet shall be provided which is equipped with a mop sink and has sufficient space for the cleaning equipment and open supplies used to maintain the patient-care unit; and
ML436			K. All clean support functions may be located in one clean workroom provided the room is carefully designed to provide adequate storage and function separations.
ML437			**8. Food service facilities shall be designed and equipped to meet the requirements of the scope of services outlined as follows:** A. Dietary facilities shall comply with 19 CSR 20-1.010;
ML438			B. In hospice facilities where food is prepared on-site, the dietary facilities shall, as a minimum, have- a storage space including cold storage for four (4) day's supply, space and equipment for food preparation to facilitate efficient food preparation and to provide for a safe and sanitary environment, conveniently located handwashing facilities, space for preparing food for distribution to patients, warewashing facilities which are isolated from the food preparation and serving area, and storage facilities for waste which is inaccessible for insects and rodents and accessible to the outside for pickup or disposal.
ML439			C. The warewashing processes shall produce dietary ware which is free of pathogenic organisms; and
ML440			D. In hospice facilities where the food service is provided through a vendor contract, dietary facilities shall, as a minimum, include space for receiving and holding the food transport equipment, utility connections for food transport equipment to maintain appropriate serving temperatures, and a holding area for soiled dietary ware transport equipment which is out of the patient area and located near the service entrance for pick-up.
ML441			(B) **Service facilities shall meet the following standards**: 1. **Services including Linen Service.** A. Service facilities shall be provided in each inpatient hospice facility and located to be out of the normal public and clinical traffic flow.
ML442			B. A weather-protected service entrance shall be provided separate from entrances used by public and patients.
ML443			C. Space and facilities shall be provided for the sanitary storage and disposal of waste. Exterior dumpsters will suffice provided they can be accessed under the protection provided at the service entrance.
ML444			D. A general storage room shall be provided with an area not less

			than ten (10) square feet per bed for the first fifty (50) beds, plus eight (8) square feet per bed for the next twenty-five (25) beds, plus five (5) square feet per bed for any additional beds over seventy-five (75). No storage room shall be less than one hundred (100) square feet of floor space. Off-site storage is acceptable, however, one half (1/2) of the required storage space shall be located in the inpatient hospice facility. General storage shall be concentrated in one (1) area.
ML445			E. Space shall be provided to house mechanical equipment. The space shall be adequate for initial installation and on-going maintenance access for each component of the systems housed in it. Mechanical equipment shall not be installed in rooms designated to house other functions.
ML446			F. A housekeeping room shall be provided with a janitor's sink and space to store opened containers of cleaning supplies and housekeeping equipment used to maintain the facility. This room is not required if the hospice is maintained by a contract cleaning service which transports the necessary cleaning supplies and equipment to the facility on a daily basis.
ML447			G. An oxygen storage room shall be provided. This room shall be enclosed with one- (1)-hour rated construction and shall have a powered or gravity vent to the outside. Permanent racks or fasteners shall be provided and used in the oxygen storage room to prevent accidental damage or dislocation of oxygen cylinders. In facilities storing quantities of oxygen less than fifteen hundred (1500) cubic feet in total, a power ventilated storage cabinet will comply. No ventilated gas storage facilities are required in hospices which store no medical gases within the building.
ML448			H. Laundry services may be provided by the hospice operator or may be obtained through contract with a linen service vendor. If laundry for the facility is done commercially, either entirely or in part, space shall be provided for the sorting, processing and storing of both soiled and clean linen. Storage space shall be located to facilitate convenient pickup and delivery by commercial laundry personnel. Hospices with only one (1) patient care unit may accommodate these functions within the utility facilities provided in the unit's staff support area.
ML449			I. Hospice-operated laundry facilities shall be designed and procedures instituted to prevent cross-contamination of clean and dirty linen. The laundry room shall be in a separate room from the kitchen, patients' rooms, the dining room and the bathrooms or the nursing utility room. Adequate space shall be provided in the laundry room for the storing, sorting and processing of soiled linen. The processes of the laundry operation shall be appropriate to the production of patient linens which are free of pathogenic organisms. Space shall be provided for the storage of clean linen in a separate room from the laundry.
ML450			J. As may be required by the program, laundry facilities provided for cleaning patients' clothing exclusively shall be located in the patient care unit but in a room separate from other functions. A residential-style laundry equipment installation is acceptable.

ML451			K. As required by the program, living and sleeping quarters, separate from patients' facilities, shall be provided for the employees and their families who may reside in the facility;
ML452			2. **Elevators.** A. All inpatient hospice facilities having patient-care facilities located on any floor other than the main entrance floor shall have at least one (1) electric or electrohydraulic elevator. Hospice facilities with more than thirty (30) beds located on any floor other than the main entrance floor shall have at least two (2) elevators. Hospice facilities with more than two hundred (200) beds located on any floor other than the main entrance floor shall provide passenger and service elevators in numbers and at locations determined by a professionally conducted study of the hospice operation and its estimated vertical transportation needs.
ML453			B. Inside dimensions of patient-use elevators shall be not less than five feet four inches by eight feet (5'4" X 8') with a capacity of three thousand five hundred pounds (3500 lbs.). Cab and hoistway doors shall be not less than three feet ten inches (3' 10") clear opening.
ML454			C. Elevators shall be equipped with an automatic leveling device of the two- (2)-way automatic maintaining type with an accuracy of plus or minus one-half inch.
ML455			D. Elevator call buttons, controls and door safety stops shall be of a type that will not be activated by heat or smoke.
ML456			E. Elevator controls, alarm buttons and telephones shall be accessible to wheelchair occupants and usable by others with various physical disabilities.
ML457			F. Elevator hoistway doors shall be fire rated to maintain the integrity of the fire-rated shaft enclosure;
ML458			3. **Chutes and dumbwaiters**. A. Chutes and dumbwaiters may be installed in hospice facilities as required by the operational program.
ML459			B. Linen and trash chutes shall be of fire-resistant material and shall be installed with flushing ring, vent to atmosphere and floor drain at the floor of the chute discharge. An automatic sprinkler shall be provided at the top of each linen and trash chute.
ML460			C. Service openings to chutes shall not be located in corridors or passageways but shall be located in a room having a fire-resistant construction of not less than one (1) hour. Doors to the rooms shall be not less than three-fourths- (3/4)-hour labeled doors equipped with an automatic closing device.
ML461			D. Service openings to chutes and other vertical openings shall have an approved self-closing labeled fire door rating not less than the fire-resistant rating of the shaft in which the chute is installed.
ML462			E. Chutes shall discharge directly into collection rooms separate from the incinerator, laundry or other services. Separate collection rooms shall be provided for trash and for linen. These rooms shall have a fire-resistant construction of not less than one (1) hour. Doors to these rooms shall be not less than three-fourths- (3/4)-hour labeled doors equipped with an automatic

			closing device.
ML463			F. Dumbwaiters, conveyors and material-handling systems shall not open directly into a corridor or exitway but shall open into a room enclosed by construction having a fire resistance of not less than one (1) hour and provided with a three-fourths- (3/4)-hour labeled fire door with a self-closing device.
ML464			G. Where horizontal conveyors and material-handling systems penetrate fire-rated walls or smoke walls, the penetrations shall be protected to maintain the integrity of the wall;
ML465			4. **General Design, Finish and Life Safety Requirements.** A. A continuous system of unobstructed corridors, referred to as required corridors, shall extend through the enclosed portion of each story of the building, connecting all rooms and spaces with each other and with all entrances, exitways and elevators, with the following exceptions: work suites such as the administrative suite and dietary area, which are occupied primarily by employed personnel, may have within them corridors or aisles as considered advisable, but are not subject to the regulations applicable to required corridors. Areas may be open to the required corridor system as permitted by NFPA 101 (1994), *The Life Safety Code.*
ML466			B. The arrangement of the physical plant shall provide for separation of the administrative/business, service and public areas from patient service areas.
ML467			C. Ceilings shall be at a height of at least eight feet (8'). Ceilings in corridors, storage rooms, toilet rooms and other minor rooms shall not be less than seven feet six inches (7' 6"). Suspended fixtures located in the path of normal traffic shall not be less than six feet eight inches (6' 8") above the floor.
ML468			D. Handrails may be provided on both sides of all corridors and aisles used by patients and, if provided, corridor handrails shall have ends return to the wall.
ML469			E. New inpatient hospice facilities shall be designed and constructed in compliance with Chapters Five through Seven and Chapter Twelve of NFPA 101 (1994), *Life Safety Code* and NFPA 99 (1993) *Standard for Health Care Facilities,* NFPA 13 (1994) *Standard for Installation of Sprinkler Systems* and NFPA 90A (1993) *Standard for the Installation of Air Conditioning and Ventilation Systems.* Section 12-6 of NFPA 101 shall not apply to these facilities.
ML470			F. Hardware on toilet room doors shall be operable from both the inside and the outside. All toilet room doors shall provide a net clear opening of not less than thirty-two inches (32").
ML471			G. The corridor doors from all patient-use areas as well as all doors through which patients may need to pass for emergency exit shall be not less than thirty-six inches (36") wide.
ML472			H. Every window in patient-use areas shall be provided with shades, curtains or drapes. Curtains and drapes shall be made of fabric which is treated to be or is inherently flame-retardant.
ML473			I. The floors of toilets, baths, utility rooms and janitor's closets shall have smooth, waterproof surfaces which are wear-resistant. The floors of kitchens and food preparation areas

			shall be waterproof, greaseproof, smooth and resistant to heavy wear.
ML474			J. The walls of all rooms where food and drink are prepared, served or stored shall have a smooth surface with painted or equally washable finish. At the base they shall be waterproof and free from spaces which may harbor insects. The walls of kitchens, utility rooms, baths, warewashing rooms, janitor's closets and spaces with sinks shall have waterproof, painted, glazed, or similar finishes to a point above the splash and spray line.
ML475			K. The ceilings of all kitchens, sculleries and other rooms where food and drink are prepared shall be painted with washable paint.
ML476			L. All casework in the facility shall be finished with at least a sealer on all interior surfaces. Casework with sinks installed in the counter shall be caulked to provide a watertight joint between the backsplash and the wall.
ML477			M. All floor covering used in inpatient hospice facilities shall have either Class A or B fire ratings as required by Chapter Twelve of NFPA 101 (1994), *The Life Safety Code.*
ML478			N. Stairways, ramps, elevator hoistways, light or ventilation shafts, chutes and other vertical openings between stories shall be enclosed with construction which is equal to or greater than the required floor assembly rating of the building's construction type.
ML479			O. The number of stories in a building housing a hospice facility shall be determined by counting the number of occupiable levels in the building regardless of their location at, above or below grade.
ML480			P. Each room or patient-use area shall be conspicuously and unmistakable identifiable at its entrance by patients, visitors and staff.
ML481			Q. All signage within six feet (6;) of the floor shall be tactile to be usable by visually impaired persons.
ML482			R. Fire-Resistant Ratings- (I) Definitions- (a) Fire separation distance is the distance in feet measured from the building face to the closest interior lot line, to the centerline of a street or public way or to an imaginary line between two (2) buildings on the same property. (b) Fire-protection rating is the time in hours, or fractions of an hour, that an opening protective assembly will resist fire exposure as determined in accordance with the test procedures set forth in *ASTM E119.*
ML483			(II) Exterior walls with a fire-separation distance less than five feet (5') shall have a fire-resistant rating of one (1) hour.
ML484			(III) In exterior walls with a fire-separation distance of three feet (3') or less, no openings will be allowed, from three feet to five feet (3 - 5') no unprotected openings will be allowed, and protected openings will be allowed with a total aggregate area of fifteen percent (15%) of the wall surface.
ML485			(IV) Approved fire protective assemblies shall be fixed, self-

			closing or equipped with approved automatic-closing devices, a fire-resistant rating of not less than three quarters (3/4) of an hour shall be required.
ML486			(V) Fire protective assemblies are not required where outside automatic sprinklers are installed for the protection of the exterior openings. The sprinklers shall be installed in accordance with *NFPA 13;*
ML487			5. **Structural Design.** A. All new facilities and additions to all areas of existing licensed facilities which undergo major remodeling, in all their parts, shall be of sufficient strength to resist all stresses imposed by dead loads, live loads and lateral or uplift forces such as wind, without exceeding, in any of the structural materials, the allowable working stress established for these materials by generally accepted good engineering practice.
ML488			B. Foundations shall rest on solid ground or properly compacted fill and shall be carried to a depth of not less than one foot (1') below the estimated frost line or shall rest on leveled rock or load-bearing piles when solid ground is not encountered. When engineered fill is used, site preparation and placement of fill shall be done under the direct full-time supervision of the soils engineer. The soils engineer shall issue a final report on the compacted fill operation and certify its compliance with the job specifications. Reasonable care shall be taken to establish proper soil-bearing values for soil at the building site. If the bearing capacity of an soil is in question, a recognized load test may be used to determine the safe bearing value. Footings, piers and foundation walls shall be adequately protected against deterioration from the action of groundwater;
ML489			6. **Electrical systems.** A. The entire electrical system shall be designed, installed and tested in compliance with NFPA 70 (1993) *The National Electrical Code* and NFPA 99 (1993) *Standard for Health Care Facilities.*
ML490			B. Emergency lighting shall be provided for exits, stairs and exit access corridors which shall be supplied by an emergency service and automatic electric generator or battery lighting system. This emergency lighting system shall be equipped with an automatic transfer switch. If battery lights are used, they shall be wet cell units or other rechargeable-type batteries equipped with automatic trickle charger. These units shall be rated at four (4) hours.
ML491			C. Patient rooms shall have a minimum general illumination of ten (10) foot-candles, a nightlight and a patient's reading light. The general illumination fixtures and the nightlight shall be switched at the patient room door.
ML492			D. Ceiling lighting fixtures, if used, shall be of a type which are shaded or globed to minimize glare.
ML493			E. Each patient room shall have not less than one (1) duplex receptacle on each wall in the room. The spacing of receptacles around the perimeter of the room shall not be greater than twelve feet (12').
ML494			F. All occupied areas shall be adequately lighted as required by the duties performed in the space.

ML495			G. Nightlights shall be provided in corridor, stairways and patient rooms. Toilets adjacent to patient rooms are not required to have night lights.
ML496			H. An electrically powered communication system shall be provided which allows staff to respond to patient calls regardless of patient location.
ML497			I. An electrically powered fire alarm system shall be provided as required by NFPA 101 (1994) *The Life Safety Code*. The fire alarm system shall have an emergency back-up source of electrical power and a direct connection for notifying the fire department or fire department dispatch service. Fire alarm manual pull stations shall be provided at each exit and at each staff work station in the patient care units. Smoke detectors shall be installed in social space rooms which open directly to the corridor, in the vicinity of any smoke or fire door which is permitted to be held open by a magnetic hold-open device, and in the corridors at intervals not exceeding thirty feet (30').
ML498			J. Portable fire extinguishers shall be provided as required by NFPA 101 (1994) *The Life Safety Code* and the local authority.
ML499			7. **Mechanical Systems.** A. The heating, ventilation and air conditioning systems shall be capable of providing temperature ranges between seventy-two degrees Fahrenheit and eighty degrees Fahrenheit (72°F-80°F) in all patient care areas. The heating system shall be capable of maintaining a winter indoor temperature of not less than seventy-two degrees Fahrenheit (72°F) in all nonpatient areas. The air conditioning system shall be capable of maintaining a summer indoor temperature of not more than eighty degrees Fahrenheit (80°F) in all nonpatient areas.
ML500			B. The heating system shall have automatic controls adequate to provide comfortable conditions in all portions of the building at all times.
ML501			C. Heating, ventilation and air conditioning systems installed in inpatient hospice facilities shall be designed, installed and balanced in compliance with NFPA 90A (1993) *Standard for the Installation of Air Conditioning and Ventilation Systems,* and shall provide the pressure relationships and at least the minimum air change rates indicated in Table 1.

TABLE 1--VENTILATION REQUIREMENTS

Area Designation	Pressure Relationship to Adjacent Areas	Minimum Air Changes of Outdoor Air Per Hour Supplied to Room	Minimum Total Air Changes Per Hour Supplied to Room	All Air Exhausted Directly to Outdoors	Air Returned From This Room
Patient Room	E	2	2	Optional	Optional
Patient Area Corridor and Patient Living Room	P	2	2	Optional	Optional
Soiled Work Room and Soiled Linen Holding	N	Optional	6	Yes	No
Clean Staff Work Area	P	2	6	Optional	Optional
Toilet Room	N	Optional	6	Yes	No
Clean Linen Storage	P	Optional	2	Optional	Optional
Designated Smoking Area	N	Optional	10	Yes	No
Food Preparation Area	E	2	6	Yes	No
Warewashing	N	Optional	6	Yes	No
Dietary and General Storage	V	Optional	2	Optional	Optional
Linen and Trash Chute Room	N	Optional	6	Yes	No
Medical Gas Storage and Manifold Rooms	N	Optional	6	Yes	No
Administrative and Public Areas	E	2	2	Optional	Optional

P = Positive
N = Negative
V = Variable
E = Equal

ML502			D. All air-moving, heating, ventilation and air-conditioning equipment shall be equipped with at least one (1) filter located upstream of the conditioning equipment. If a pre-filter is employed, the pre-filter shall be upstream of the conditioning equipment and the main filter shall be located farther downstream. All filters shall be easily accessible for maintenance. Filter frames shall be durable and carefully dimensioned and shall provide an airtight fit with the enclosing ductwork. All joints between the filter segments and the enclosing ductwork shall be sealed to preclude air leakage.
ML503			E. Outside air intakes shall be located no less than twenty-five feet (25') from exhaust outlets of ventilation systems, combustion equipment stacks, clinical suction discharges and plumbing vent stacks or from areas which may collect vehicular exhaust and other noxious fumes.
ML504			F. Corridors shall not be used to supply air to or exhaust air from any room, except that air from corridors may be used to ventilate bathrooms, toilet rooms, janitor's closets and small electrical or telephone closets opening directly onto corridors provided that ventilation can be accomplished by the undercutting of doors. The installation of louvers in corridor doors is prohibited. The space above the finished ceiling may be used as a plenum for return air only.
ML505			G. Exhaust hoods in meal preparation areas shall comply with the requirements of NFPA 96 (1994). All hoods and cooktop surfaces in meal preparation areas shall be equipped with automatic fire suppression systems, automatic fan controls and

			fuel shutoff;
ML506			8. **Plumbing Systems.** A. The entire plumbing system, its design, operation and maintenance shall comply with the requirements of all applicable local and state codes including the requirements set forth in this rule.
ML507			B. Plumbing Fixtures. (I) All plumbing fixtures shall be of nonabsorptive acid-resistant material.
ML508			(II) Clinical sinks shall have a bedpan-flushing device and shall have an integral trap in which the upper portion of a visible trap seal provides a water surface.
ML509			(III) Showers and tubs shall be provided with nonslip surfaces.
ML510			(IV) Water closets in patient areas shall be quiet operating types.
ML511			(V) Stools in patient toilet facilities shall be the elongated bowl type with nonreturn stops, backflow preventers and silencers. Seats shall be the split type and white in color.
ML512			(VI) Grab bars or handrails shall be provided adjacent to all bathtubs.
ML513			(VII) All lavatories shall be trimmed with valving operable without the use of hands.
ML514			C. Water Supply Systems. (I) A reliable source of potable water shall be provided at the site to supply water in sufficient quantities to meet the various use demands of the hospice. The source of water shall have been tested and approved by the Missouri Department of Natural Resources.
ML515			(II) The water supply systems shall be designed to supply water at sufficient pressure to operate all fixtures and equipment during maximum demand periods.
ML516			(III) Each water service main, branch main, riser and branch to a group of fixtures shall be valved. Stop valves shall be provided at each fixture.
ML517			(IV) Reduced pressure backflow preventers shall be installed on water service entrance, hose bibbs, janitors' sinks, bedpan flushing attachments, and on all other fixtures to which hoses or tubing can be attached. The installation of backflow preventors shall provide safeguards against waterline expansion.
ML518			(V) The water supply system shall be designed to provide hot water at each hot water outlet at all times. The water-heating equipment shall have sufficient capacity to supply five (5) gallons of water at lone hundred twenty degrees Fahrenheit (120°F) per hour per bed for hospice fixtures and eight (8) gallons per bed for kitchen and laundry. Lesser capacities may be accepted upon submission of the calculation for the anticipated demand of all fixtures and equipment in the building. Hot water at showers and bathing facilities shall not exceed one hundred ten degrees Fahrenheit (110°F). Hot water at handwashing facilities shall not exceed one hundred twenty degrees Fahrenheit (120°F). Hot water circulating mains and risers shall be run

			from the hot storage tank to a point directly below the highest fixture at the end of each branch main.
ML519			D. Drainage Systems. (I) All fixtures and equipment shall be connected through traps to soil and waste piping and to the sewer and they shall all be properly vented to the outside.
ML520			(II) Courts, yards and drives which do not have natural drainage from the building shall have catch basins and drains to low ground, storm-water drainage system or dry wells.
ML521			(III) The building sanitary drain system shall be piped in cast iron, steel, copper or plastic.
ML522			(IV) Building sewers shall discharge into a community sewerage system when available. If such a system is not available, a facility providing sewage treatment shall conform to the rules of the Department of Natural Resources.
ML523			(V) Drainage piping shall not be installed within the ceiling or exposed in food preparation centers, food service facilities, food storage areas and clean linen storage rooms; special precautions shall be taken to protect any of these areas from possible leakage or condensation from necessary overhead drainage piping systems. These special precautions include requiring noncorrosive drip troughs with a minimum four-inch- (4")-outside diameter to be installed under the drainage pipe in the direction of slope to a point where the pipe leaves the protected space and terminates at that point - usually at a wall. The trough shall be supported with noncorrosive strap hangers and screws from the pipe above. Trough joints and hanging screw penetrations shall be sealed to maintain watertight integrity throughout.
ML524			E. Natural or Liquefied Petroleum (LP) Gas Systems. (I) Where gas-fire equipment is used, all gas piping, fittings, tanks and specialties shall be provided and installed in compliance with NFPA 54 (1992, NFPA 58 (1992), and the instructions of the gas supplier, except where more strict requirements are stated. Where liquefied petroleum gas (LPG) is used, compliance with the rules of the Missouri Department of Agriculture is also required.
ML525			(II) Where gas piping enters the building below grade, it shall have an outside vent as follows: a concrete box shall be made eighteen inches by eighteen inches (18" X 18") with three-inch (3") thick walls, of a height to rest on top of the entering gas pipe, and the top of the box to coming within six inches (6") of top grade. The box shall be filled with course gravel. A one-inch (1") upright vent line shall be to one-half (1/2) the depth of the box and extend twelve inches (12") above grade with a screened U-vent looking down. The vent line shall be anchored securely to the building wall.
ML526			(III) Gas outlets and gas-fired equipment shall not be installed in any patients' bedrooms.
ML527			F. Where a piped central medical gas distribution system is installed, the oxygen piping, outlets, manifold rooms, and storage rooms shall be installed in accordance with the requirements of

			Chapter 4 of NFPA 99 (1993); and
ML528			9. **Fire Prevention and General Operating Requirements.** A. The hospice facility shall be maintained in a manner which provides a clean safe environment for the delivery of patient care and shall, until remodeled or renovated with the approval of the Department of Health, remain compliant with the codes and regulations under which the facility was constructed.
ML529			B. Exitways shall always be maintained free of obstructions.
ML530			C. Curtains, drapes and cubicle curtains shall be maintained in a manner which does not compromise their fire-resistant properties.
ML531			D. Smoking may be permitted in the patient's room by the patient only, and designated smoking areas by others. Designated smoking areas shall be ventilated as required by Table 1 of this rule. Modification of the patient room ventilation system is not required to permit occasional authorized smoking by a patient.
ML532			E. All waste containers shall be of noncombustible construction.
ML533			F. Electrical systems and medical gas systems shall be tested according to the provisions of NFPA 99 (1993) and shall be modified as necessary to comply with the operational requirements of that standard.
ML534			(5) **General Design and Construction Standards for Existing Inpatient Hospital Facilities.** Any inpatient hospice facility existing and in continuous operation prior to the date of October 30, 1996, will upon receipt of application for licensure, be inspected by the Department of Health to determine compliance with this rule. Where existing physical conditions cause strict compliance to be difficult to achieve, the department may determine that the intent of the new construction rules has been satisfied through the establishment of acceptable equivalency conditions. The provision of fire alarm and detection systems, automatic extinguishment systems, building compartmentation and the presence of staff trained consistent with the facility's disaster preparedness plan are factors which will be considered in determining fire safety compliance equivalency. The ability of the existing facility to meet the programmatic needs of the patients, their family, staff and public in an accessible and sanitary environment will be considered in determining functional equivalency. Existing inpatient hospice facilities shall provide the department evidence of compliance with all local regulations and codes as well as evidence that the existing operation is in good standing with the health facility licensure programs administered by Department of Social Services/Division of Aging. Existing inpatient hospice facilities shall be operated and licensed exclusively under the provisions of section 197.250, RSMo.